MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (X) No
Requestor's Name and Address Dr. Alan Berg 7125 Marvin D. Love #107 Dallas, TX 75237	MDR Tracking No.: M4-04-4177-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address TASB Risk Management Fund P.O. Box 2010 Austin, TX 78768 Box 12	Date of Injury: Employer's Name: Wilmer Hutchins ISD Insurance Carrier's No.: 0253331024016126

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
01/07/03	03/13/03	97110, 97799-JA, 97750	$916.00	$737.00

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 11/21/03 states in part, "…According to TWCC MFG for 97750 Physical Performance Evaluation, the reimbursement is $43.00 per unit. Our charge was for 8units and should be reimbursed… our charges for Job Assessment was denied stating that the examiner was not within the scope of practice/licensure of the billing. Our resubmission included the examiners license information. The examiner is an employee with our company and billed under the direction of the treating doctor… For date of service 1-7-03 our charge was denied as not documented. We resubmitted with documentation and the reconsideration audit was done incorrectly entering date of service 1-6-03 instead of the correct date of 1-7-03, this caused a duplication denial. We again resubmitted in stating that the date of service was entered wrong and it needed to be corrected to have a valid audit. The carrier replied with the correct date of service 1-7-03 denying once again…"

PART IV: RESPONDENT'S POSITION SUMMARY

The Respondent did not respond to the TWCC-60 or the request for additional information.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Code 97110 for date of service 01/07/03 denied as "N 10 – Not documented". Per Rule 133.307(g)(3)(B) the requestor did not submit pertinent medical records to support the services were rendered as billed. Reimbursement is not recommended.

- CPT Code 97799-JA (12 units total) for date of service 01/09/03 denied as "K – This procedure is not within the scope of practice/licensure of the billing". Per 134.801(e)(4), submitted information supports the services were administered by an employee of the treating physician; therefore, reimbursement in the amount of $737.00 is recommended.

- CPT Code 97750 (8 units/15 min each) for date of service 03/13/03 denied as "F1 – Reduction according to Fee Guideline. Charge exceeds the schedule maximum allowance per the Medical Fee Guideline". Per the 1996 Medical Fee Guideline CPT Descriptor, the physical performance test or measurement with report is a timed code billed in 15 minutes increments. Per Rule 133.307(g)(3)(B) the requestor did not submit the written report; therefore, MDR is unable to confirm the number of units billed. Additional reimbursement is not recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
1/7/2003	97110	$35.00	$0.00				
1/9/2003	97799-JA	$737.00	$737.00				
3/13/2003	97750	$144.00	$0.00				
				Total Left Column:			$916.00
				Total Amount Due:			$737.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $737.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Marguerite Foster Typed Name	02/04/05 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____